Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Universal DME

Respondent Name
Protective Insurance Co

MFDR Tracking Number
M4-16-2128-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
March 25, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We did not need authorization for this item per the rule 134.600 but as you will see in the attached documents, we did have an authorization from them. They also denied E0217 stating that it is not the right hcpcs code but indeed it is and that is what we were given prior authorization for #63773350-UMO-3."

Amount in Dispute: $1,466.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor did not bill for the item preauthorized. Therefore, the denial for E0217 for failure to obtain preauthorization for the item should be upheld. ….Therefore, the cumulative price for these two items is more than $500.00, and therefore, preauthorization was required."

Response Submitted by: Downs ♦ Stanford, PC 2001 Bryan Street, Suite 4000, Dallas, Texas 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 6, 2015	E0673 -NU, E0675 -RR, E0217 -RR	$1,466.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out the requirements of prior authorization.

4. 28 Texas Administrative Code §133.20 sets out the requirements of medical bill submission.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - 197 – Payment adjusted for absence of precert/preauth
   - 107 – Denied – qualifying svc not paid or identified
   - 193 – Original payment decision maintained

Issues

1. Is the carrier's denial supported?

Findings

1. The insurance carrier denied disputed service E0673 –NU, with claim adjustment reason code 107 – "Denied – qualifying svc not paid or identified." 28 Texas Administrative Code §134.203 (b) states,

   > For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
   >
   > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

   Review of the submitted medical claims finds;

   - Individual claim for code E0673 – Segmental gradient pressure pneumatic appliance, half leg

   The CMS coding policy found at, https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33829&ContrId=140&ver=22&ContrVer=2&CntrctrSelected=140*2&Cntrctr=140&name=CGS+Administrators%2c+LLC+(18003%2c+DME+MAC)&DocType=Active&LCntrctr=140*2&bc=AgACAAIAAAAAAA%3d%3d& states in pertinent part,

   > An E0675 is a PCD… ***Sleeves E0667-E0669 are used with E0675.***

   Pursuant to Rule 134.203(b) the carrier's denial is supported as the requestor submitted code E0673. No additional payment is recommended.

   The carrier denied the submitted codes E0675 as, 197 – "Payment adjusted for absence of precert/preauth with a not "Per rule 134.600(p)(12) –treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier."

   28 Texas Administrative Code §134.600(p)(12) states in pertinent part, "Non-emergency health care requiring preauthorization includes: (12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier."

   28 Texas Labor Code §137.100 (a) states in pertinent part, "Health care providers shall provide treatment in accordance with the current edition of the Official Disability Guidelines - Treatment in Workers' Comp, excluding the return to work pathways, (ODG), published by Work Loss Data Institute (Division treatment guidelines), unless the treatment(s) or service(s) require(s) preauthorization in accordance with §134.600 of this title (relating to Preauthorization, Concurrent Review and Voluntary Certification of Health Care) or §137.300 of this title (relating to Required Treatment Planning)."

   Review of the Official Disability Guidelines (ODG) finds;

   - Lymphadema pump (pneumatic compression device) "Recommend home-use as an option for the treatment of lymphedema after a four-week trial of conservative medical management that includes exercise, elevation and compression garment"

Review of the submitted medical bill finds the following;

a. Place of service submitted was "22" or Outpatient hospital
b. Submitted diagnosis code wasM75.111 – "INCMPL ROT CUFF TEAR/RUPT RT SHLDR".

The requirements of Rule 134.600(p)(12) were not met as the reported diagnosis and place of service are not addressed in the ODG guidelines thus requiring prior authorization. No additional payment can be recommended.

28 Texas Administrative Code §133.20 (c) states,

A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills.

Review of the submitted documentation finds the following:

- Submitted code in box 24D of medical claim form E0217 which is described as, "Water circ **heat** pad w/pump."
- Authorization received is for "Cryo therapy unit rental x 7 days"

The carrier denied this service in dispute as 16 – "Svc lacks info needed or has billing error(s). As the submitted code description does not match the description of the authorized services, the carrier's denial is supported.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		April , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.